



**DEPARTMENT OF MEDICAL EDUCATION  
APPLICATION FOR ACCREDITATION OF JOINT SPONSORSHIP**

**Name of Applying Organization** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Name & Title of person completing this form \_\_\_\_\_

Person Responsible for Course Accreditation, if different from above \_\_\_\_\_

**PROPOSED COURSE**

Title: \_\_\_\_\_

Course Day(s) and Date(s) \_\_\_\_\_

Beginning Time \_\_\_\_\_ Ending Time \_\_\_\_\_

List length of breaks and lunch: \_\_\_\_\_

Location: \_\_\_\_\_  
Facility \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Planning Committee: **A Physician Must Be On Planning Committee.**

This Physician will be asked to present program to the PGMC/Medical Education Committee.

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

(5) \_\_\_\_\_

**INSTRUCTIONAL DESIGN**

**1. NEEDS ASSESSMENT:** Describe the process used to determine the need for this program (check all that apply)

- Evaluation of previous CME activity identified as established need
- Data/Statistics indicate a need for program
- A need was identified through a survey
- Decision of program planning committee
- Request from outside agency/organization
- Other (please specify) \_\_\_\_\_

Briefly state the learning needs for which this program is being designed:

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**2. INTENDED AUDIENCE:** Describe for whom the program is being designed, including any special background or experience requirements of this target audience:

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**3. EDUCATIONAL OBJECTIVES:** Upon completion of this program , what knowledge and/or skills should the participants have acquired?

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

**4. EDUCATIONAL CONTENT:** What are the principle topics to be discussed in the course that is being proposed? (This is PROPOSED content. Medical Education Coordinator or Director must be able to give input on content in order to help oversee.)

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**5. EDUCATIONAL METHODOLOGY:** What methods will be utilized to present the topics?

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**PLEASE SUBMIT A COPY OF THE PROPOSED COURSE OUTLINE/PROGRAM AGENDA**

**COURSE FACULTY**

Course Chairperson: \_\_\_\_\_

Telephone #(\_\_\_\_)\_\_\_\_\_

Please List the Course Faculty, their Specialty & Affiliations (or attach a listing):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_

**TARGET AUDIENCE**

Please indicate the target populations proposed for this course (medical specialties, allied health)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**ADMINISTRATION BUDGET**

1. This program will be marketed: \_\_\_\_\_Local \_\_\_\_\_State \_\_\_\_\_Regional \_\_\_\_\_Nationally

2. Will you seek American Academy of Family Practice Accreditation \_\_\_\_\_Yes \_\_\_\_\_No  
(For a \$50 fee PEMC/Medical Education can apply for you)

3. Course Registration Fee \$ \_\_\_\_\_

Projected # of Participants \_\_\_\_\_

4. Is this course accepting funding from other sources? (i.e., pharmaceutical grants, vendor displays, government grants, etc.) \_\_\_\_\_Yes \_\_\_\_\_No

Explain \_\_\_\_\_

5. Please list any amenities that will be provided to the participants (i.e., catering, course syllabus, vendor displays, nominal gifts, etc)

Accreditation of an educational course/program by Providence Everett Medical Center attests to the quality of the program content, instructional format and effectiveness and appropriateness of the faculty. As an exemplary accredited institution, Providence Everett Medical Center sponsors only those programs that comply with, and demonstrate the ability to adhere to the Essentials and Guidelines of the Accreditation Council of Continuing Medical Education. Providence Everett Medical Center’s name may not be stated as  
Page 3 of 4

in "association with", "endorsed by" or "in cooperation with" in promoting the program. Providence Everett Medical Center will be listed as "SPONSOR". All printed materials for activities created according to the Essentials must carry the following statement:

**"This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Providence Everett Medical Center and (Insert Your Name Here).**

**"PEMC is accredited by the WSMA Continuing Medical Educational Committee to sponsor Category I CME programs for physicians. As an organization accredited to provide CME, PEMC certifies this course meets the criteria for \_\_\_hours of Category I CME to satisfy the relicensure requirements of the Washington State Board of Medical Examiners".**

Front page of the brochure must state:

**"Sponsored By Providence Everett Medical Center Department of Medical Education"**

#### FINANCIAL REQUIREMENTS

(If Not Affiliated With PEMC Medical Staff)

The normal and customary cost for Category I designation is:

\$50 Application Fee, is non-refundable and must accompany the Application for Accreditation.

\$400 1-7 Credit Hours After Application is Approved

\$650 7-25 Credit Hours After Application is Approved

This fee helps to offset the review charges, program development, administrative costs and CME certificates.

For additional costs the following can be added: brochure development, mailing labels, brochure printing, bulk mailing of brochures, syllabus, etc.

Please return this form to: PEMC/Medical Education

Attn: Jeri Sackett, CMP

1321 Colby Avenue

Everett, WA 98201

(425) 261-3690